RETIREE STATE HEALTH BENEFIT PLAN

UPDATER

GEORGIA DEPARTMENT OF COMMUNITY HEALTH *Spring, 2000*

This UPDATER constitutes official notification to State Health Benefit Plan (SHBP) members of Plan changes and, as such, supersedes any previously published information that conflicts with the material included in this UPDATER. It will be used—in conjunction with the SHBP Booklet dated November 1, 1995, the HMO Member Handbook dated March 1998, plus any UPDATER published after November 1, 1995—to administer the Plan until new booklets are published. If you are disabled and need this information in an alternative format, write the State Health Benefit Plan at P.O. Box 38342, Atlanta, GA 30334 or for TDD Relay Service only, call (800) 255-0056 (text telephone) or (800) 255-0135 (voice).

SIGNIFICANT PLAN CHANGES EFFECTIVE JULY 1, 2000

This *UPDATER* describes material changes to the State Health Benefit Plan (SHBP) for Retirees. Plan members are encouraged to read the entire document to be informed about all Plan options. Plan changes indicated herein are effective July 1, 2000. This *UPDATER* is for retired employees covered under the SHBP. If you are an active member, please refer to the Spring 2000 *UPDATER* for active members.

As you review the changes, it may be helpful to refer to the Glossary on page 25 for a description of terms.

If you have questions or need help, call the Retiree Help Line at (800) 230-2291. The Retiree Help Line is available specifically to answer questions during the Retiree Option Change Period, April 17 through May 16, 2000. Representatives are available Monday—Friday, 8 a.m. to 6 p.m., beginning April 3, 2000.

RISING MEDICAL COSTS LEAD TO SHBP PLAN CHANGES

In the face of rising medical costs, the Georgia Department of Community Health made significant changes to keep the SHBP financially sound. Overall medical costs are increasing 12.5 to 17 percent a year and premiums for SHBP members have not kept pace. The increase in medical costs without a corresponding increase in premiums has led to a serious budget shortfall.

Double-digit medical cost increases have affected benefit plans across the country, so it's not surprising that most employers turned to managed care several years ago to contain costs. In fact, very few employers continue to offer indemnity plans and only 13 percent of employees nationwide are enrolled in indemnity plans like the Standard and High Options. On the other hand, almost 75 percent of SHBP members are enrolled in one of these two options. To remain financially sound, combat increasing costs, and provide SHBP members access to quality care with an increased emphasis on preventive care, the SHBP had to make changes and expand plan options.

As these changes were made, your voices have been influential in helping the Plan to identify critical needs and concerns about your retiree medical insurance coverage.

In focus groups conducted among retirees throughout Georgia, we heard you say you wanted things like continuing high quality, fair premiums, less paperwork, faster claims processing, enhanced vision coverage, better prescription drug benefits, and a chance to change your coverage options.

The information you provided has helped the SHBP to develop a better benefit plan for retirees. We are excited about the changes and new coverage options available to you.

AN OVERVIEW OF MAJOR CHANGES

- **You can change your coverage during the first annual Retiree Option Change Period (ROCP).** In the past, the SHBP did not allow you to change health coverage options after retirement, unless you had special qualifying events. Now, for the first time, SHBP retirees have the opportunity to change their health coverage during the Retiree Option Change Period. The ROCP will occur annually in conjunction with the Open Enrollment Period for active members—mid-April to mid-May.
- **For the first time, Medicare-enrolled retirees can enroll in Medicare+Choice (M+C) HMOs.** Each of the three HMOs has a Medicare+Choice Option. If you are entitled to Medicare Part A and enrolled in Medicare Part B and live in certain counties, you should carefully consider the Medicare+Choice Options. These options offer additional benefits and lower premiums than the regular HMOs. The M+C Options include prescription drug benefits that offer the same prescription drug coverage as for active employees. M+C options also have additional enhancements like an allowance for hearing aids/exams, and vision care. (See page 6 and the accompanying *Health Plan Guide for Retirees* for more details on your new Medicare+Choice Options.)
- **A Preferred Provider Organization (PPO) Option replaces the Standard Option.** A PPO is a network of doctors, hospitals, and other providers that have agreed to offer quality medical care and services at discounted rates. Members of the PPO can choose to use this network for a higher level of coverage, or they can see any licensed provider they wish for a lower level of coverage. See pages 10-14 for more information on the new PPO Option and how it compares to the Standard Option it replaces.
- **Premiums for the High Option have increased.** Review the enclosed Rate Worksheet for your new monthly premium. There have also been a few High Option benefit changes. Refer to page 21 for a review of the benefit changes.
- **As a result of a new state law, both the PPO and the HMOs will offer Consumer Choice Options.** These options allow members to nominate non-network providers to provide care on an in-network basis. See page 9 for more information on the Consumer Choice Options.

THE FIRST RETIREE OPTION CHANGE PERIOD—APRIL 17 THROUGH MAY 16, 2000

During this first annual Retiree Option Change Period, you have the opportunity to select from several different coverage options as long as they are available in your county of residence. You can change from *any coverage option to any other option* for which you are currently eligible. This change period allows all retirees to change their health coverage option—including surviving spouses of members, and direct pay members who are currently covered. However, you cannot enroll for coverage or change from single to family coverage.

The decision you make (for yourself and your family) during this period will become effective on July 1, 2000 and remain in effect through June 30, 2001 (except as provided for M+C selections as referenced on page 5).

For More Information About the Changes

If you have questions or need help at any point during the change period, call the Retiree Help Line at (800) 230-2291. The Retiree Help Line is available specifically to answer questions during the Retiree Option Change Period. Representatives are available Monday—Friday, 8 a.m. to 6 p.m., beginning April 3, 2000 through May 16, 2000.

A REVIEW OF YOUR ENROLLMENT CHOICES

These new Medicare+Choice (M+C) options are available to you if you are entitled to Medicare Part A, are enrolled in Medicare Part B and live in certain counties—

- Aetna US Healthcare Medicare+Choice;
- BlueChoice Medicare+Choice; and
- Kaiser Permanente Medicare+Choice.

The service area and benefits for these options differ from the service area for the respective regular HMO and HMO Consumer Choice options.

These options are available if you live in the HMO's approved service area—

- Aetna US Healthcare HMO;
- Aetna US Healthcare Consumer Choice Option;*
- BlueChoice HMO;
- BlueChoice Consumer Choice Option;*
- Kaiser Permanente HMO; and
- Kaiser Permanente Consumer Choice Option.*

**Other than the ability to nominate providers, benefits are identical to the regular HMO option.*

Special Notice: *As reported in the January 2000 issue of UPDATER, Prudential coverage under the SHBP will not be available as of July 1, 2000. Members currently in the Prudential HMO will have the opportunity to select any other available option during this ROCP (for coverage effective on July 1, 2000). Please note that if you do not choose a new option during the ROCP, your coverage will automatically continue under the Standard PPO Option.*

These options are available statewide and in selected areas outside of Georgia near the border—

- The Standard PPO Option. Current Standard Option members who do not make another choice will automatically continue coverage in the Standard PPO Option. If you are a current Standard Option member living outside the PPO service area, you will automatically be transferred into High Option effective July 1, 2000, unless you elect to discontinue coverage during the open enrollment period;
- The PPO Choice Option. Other than the ability to nominate providers to be paid as network providers, benefits are identical to the Standard PPO Option.

See page 20 for PPO service area information.

The High Option is available to anyone eligible for SHBP coverage.

What You Need to Do to Change Your Coverage

In most cases, to change your coverage, you'll need to fill out a Personalized Change Form (PCF). However, in certain cases, no action may be necessary. For example, if you are currently a Standard Option member, you want to continue coverage in the Standard PPO Option, and you live in the PPO service area, your coverage will continue automatically. The chart below shows what actions you need to take based on your enrollment choices.

What to do if:

	You're currently enrolled in:					
And you want to enroll in:	**High Option**	**Standard Option**	**Aetna US Healthcare HMO**	**BlueChoice HMO**	**Kaiser Permanente HMO**	**Prudential HMO**
High Option	**No action necessary**	Complete a PCF				
Standard PPO Option	Complete a PCF	**No action necessary**	Complete a PCF			**No action necessary**
Consumer Choice PPO	Complete a PCF					
Aetna US Healthcare HMO	Complete a PCF		**No action necessary**	Complete a PCF		
Aetna US Healthcare Consumer Choice HMO	Complete a PCF					
Aetna US Healthcare Medicare+ Choice	Complete a PCF and Medicare+Choice Form See *Health Plan Guide* for Instructions					
BlueChoice HMO	Complete a PCF			**No action necessary**	Complete a PCF	
BlueChoice Consumer Choice HMO	Complete a PCF					
BlueChoice Medicare+ Choice	Complete a PCF and Medicare+Choice Form See *Health Plan Guide* for Instructions					
Kaiser Permanente HMO	Complete a PCF				**No action necessary**	Complete a PCF
Kaiser Permanente Consumer Choice HMO	Complete a PCF					
Kaiser Permanente Medicare+ Choice HMO	Complete a PCF and Medicare+Choice Form See *Health Plan Guide* for Instructions					

To change your option on line, visit www.statehealth.org between april 17, 2000 and May 16, 2000.

How to Get Confirmation of Your Option Change

- If you make changes to your current coverage by mail, you will receive a new ID card by mail around July 1, 2000 confirming your election for Plan year 2000-2001.
- If you make changes to your current coverage online using the SHBP Web site, you can print a confirmation of your option change directly from the Web site. If a printer is not available to you, simply write the confirmation number you'll see on your computer screen in the space provided on your PCF.
- In each case, review your PCF as soon as you get it to make sure it's right. If your address is incorrect, mark though the address on the form and "write in" the correct address. If you see other errors on the form, contact the Retiree Help Line at (800) 230-2291.

Important Note: If you have medical coverage under another plan, like your spouse's medical plan, you may decide not to choose medical coverage with the SHBP. However, if you choose "No Coverage" for Plan year 2000-2001, you will not be able to reenroll in an SHBP option at any time in the future, unless you return to active employment in a benefits eligible position.

MAKING MIDYEAR CHANGES

In addition to the annual Retiree Option Change Period, you can also make changes during the year under the following circumstances:

- **You have a qualifying event during the Plan year.** Qualifying events include marriage, divorce, a new dependent, your spouse loses or gains coverage through his or her employment, death, attainment of Medicare eligibility, or moving out of an HMO or the PPO service area. If you need to change your election because of a change in family status, your new election must be filed with the SHBP within 31 days of the qualifying event. *(Refer to the SHBP booklet titled State Health Benefit Plan, November 1, 1995 and subsequent UPDATERS for a complete description of qualifying events.)*
- **You decide the Medicare+Choice HMO option you've chosen is not right for you.** You are encouraged to consider enrolling in the Medicare+Choice HMO option. Because the Plan recognizes that an enrollment in an M+C option may be a big change for you, the Plan is giving you a trial period this first year. If you are dissatisfied with your choice, you can reverse your decision for effective dates of October 1, 2000, November 1, 2000, December 1, 2000, or January 1, 2001. You must file the request to reverse your decision to enroll in an M+C HMO at least 30 days before the effective date and no later than December 1, 2000. Or, rather, than reverse your decision, you can choose the Standard PPO.
- **If you choose the Medicare+Choice HMO and you decide to reverse your decision, coordination with Medicare is critical.** Please contact the eligibility section of the SHBP at (800) 610-1863 or in Atlanta, (404) 656-6322 for assistance with reversing your decision.
- **The Medicare+Choice trial period is only for the Retiree Option Change Period for Plan year 2000–2001.** If you miss the December 1, 2000 deadline, you will have an opportunity to make an option change during the next annual Retiree Option Change Period. The effective date of that change would be July 1, 2001.

A CLOSER LOOK AT THE STATE HEALTH BENEFIT PLAN OPTIONS

NEW HMO OPTIONS CAN SAVE YOU MONEY

For detailed information about these HMO Options, refer to the accompanying *Health Plan Guide for Retirees*.

Who Can Join

You must live in the approved HMO service area to join the regular HMOs and the Consumer Choice HMOs. Before making your enrollment decisions, you should refer to the Service Area charts in the accompanying *Health Plan Guide for Retirees* to make sure you are eligible.

Physicians and Other Providers

You receive coverage when in-network providers are used for covered services. Generally, except for emergency care, services are not covered outside of the HMO's provider network. You are required to select a Primary Care Physician and, in most cases, referrals are required to see specialists.

Copayments, Deductibles, and Coinsurance

Generally there are no deductibles to pay. Instead, you pay an in-network office visit copayment each time you see a physician in his or her office and when you obtain a prescription. Hospitalization and other services are usually covered at 100%.

Preventive Care Coverage

Although benefits vary by HMO, HMOs generally offer very broad preventive care coverage as long network providers are seen.

Introducing the Medicare+Choice HMO Options

Each of the HMO options has a Medicare+Choice option connected with it. M+C HMOs provide comprehensive coverage for medical services for Medicare+Choice enrolled persons at lower premiums than the regular HMOs. As long as you continue paying your Part B premiums, your benefits as an M+C member will be greater than traditional HMO benefits. If you choose an M+C HMO for medical coverage, all care must be arranged by the M+C HMO providers for you to receive benefits—except for emergency or acute care. To be eligible to choose an M+C option, you must live in an M+C service area.

Note: Currently, M+C HMOs are available in Metro Atlanta service areas only.

How Medicare+Choice Can Affect Your Current Medicare Coverage

If you choose an M+C Option, your new coverage will replace your traditional Medicare coverage. Your claim forms will no longer be filed with Medicare and the SHBP. All of your services and payments would be coordinated through the M+C HMO.

Although Medicare+Choice HMO benefits vary by HMO, most include some benefits not covered by Medicare, including prescription drugs, vision care, hearing aids, and expanded preventive care, including annual physical examinations.

If you enroll in a Medicare+Choice option, you will continue to pay the Medicare Part B premium, usually deducted from your monthly Social Security benefit checks. Your coverage will be based on the rules of the M+C option, which can offer you the advantages of low out-of-pocket costs, reduced paperwork, and low premiums. Medicare pays a portion of your premium directly to the HMO. In addition to the Part B premium, you pay an SHBP premium, however it will be lower than regular HMO option coverages.

Introducing HMO Consumer Choice Options

In addition to the Medicare+Choice Option, each of the three HMO Options have a respective Consumer Choice Option. Eligibility rules and benefits are identical to the regular HMO Option. The difference is the ability to nominate providers to provide care on an in-network basis. Consumer Choice Options are not available for Medicare+Choice Plans. For more information on Consumer Choice, see page 9.

THE NEW PPO OPTIONS COMBINE COST SAVINGS AND CHOICE

PPO Network Offers Broad Physician and Hospital Choices

Another significant change to your benefits is the replacement of the Standard Option with the new Standard PPO Option. The new Standard PPO Option represents a commitment to controlling rising costs without sacrificing quality or freedom to choose doctors and hospitals. The PPO network is actually a combination of two provider networks that joined to offer comprehensive provider access across the state and in selected areas near Georgia's border. The combined network includes more than 8,500 physicians, 151 hospitals, and a comprehensive ancillary and chiropractic network.

This large number of physicians includes 94% of the doctors currently providing services to Standard and High Option members. That means that many Standard and High Option members will find their current physicians included in the PPO network. In addition, over 90% of the hospitals in the state of Georgia are included in the network. The PPO network also includes hospitals and doctors near the Georgia border in Florida, Tennessee, Alabama, and South Carolina.

The enclosed PPO Provider Directory includes the doctors, hospitals, and other providers in the PPO network. You can also find the directory on the internet at www.communityhealth.state.ga.us.

The Standard PPO Option

The Standard PPO Option provides many of the advantages of indemnity-type plans, like the High and former Standard Options. When you need care, you make the decision to see a PPO network provider or to see any licensed provider outside the PPO network. It's your choice at the time you receive care, but your level of benefit coverage will be reduced if you see a non-network provider, and you may have to file claims. If you use in-network providers, they will file claims for you.

PPO Choice Option

In addition to the Standard PPO Option, you also have the option of joining the PPO Choice Option. The eligibility rules and benefits are identical to the Standard PPO Option, but you have the ability to nominate providers with a valid Georgia license who are not in the PPO network. For more information on Consumer Choice, see page 9.

Who Can Join the PPO

Although you must use a network provider to receive the highest level of benefit coverage, the PPO is available to anyone eligible for SHBP coverage who lives or works in Georgia or in selected areas near the Georgia border. See page 20 for the PPO's service area.

Special Note: If you are a current Standard Option member not eligible to join the PPO, you will automatically be transferred into High Option effective July 1, 2000, unless you elect to discontinue coverage during the ROCP.

Coordinating Benefits Between the New PPO Options and Medicare

For Medicare-enrolled retirees, benefits are coordinated with Medicare. The SHBP is considered secondary and Medicare is considered your primary coverage. That means that Medicare pays for your coverage first and what Medicare doesn't pay, your SHBP benefit plan often will. For example, when you're ill, you'll generally receive 100% of the hospital and physician allowed amount after you meet the general deductible—from the combination of Medicare and the SHBP payments. Under the new PPO, prescription drugs will always be paid at 90% rather than 100% of the pharmacy network rate.

If you are enrolled in Medicare Parts A and B, the PPO Options will continue to provide payment at the secondary amount for in-network and out-of-network services. In cases where you use an out-of-network provider, the out-of-network deductible must be met before the secondary payment will be made. If you use both in-network and out-of-network providers, the secondary payment will depend on whether the specific deductible has been met.

You Can Choose to See Any Providers Within the PPO Network

The doctors, hospitals, and other providers included in the PPO network are located throughout the state and in selected areas near the Georgia border. Within this network, you can see any physician or other provider you wish. You do not have to choose a primary care physician (PCP) to direct your care or to refer you to specialists.

In-Network Copayments, Deductibles, and Coinsurance

You pay a fixed $20 copayment for office visits. Other than for preventive care and illness/injury office visits, you must meet a yearly general deductible of $300 per person ($900 family maximum) before benefits are payable. In network, the Plan generally pays 90% of the network rate and you pay 10% of the network rate. You are not subject to balance billing when you see in-network providers. (See Glossary for balance billing definition.) When you use in-network providers, your providers will file all claim forms for you. When claims are paid, you will continue to receive an explanation of benefits (EOB) showing what portion of your claim the Plan paid and other useful information.

In-Network Preventive Care Coverage

You're covered for a wide variety of preventive care services—such as annual check-ups, well-baby care, and immunizations—and best of all, no deductibles apply. Lab work and tests associated with preventive care office visits are covered too—at 100% up to $500 per person per year. This includes coverage for mammograms, Pap smears, PSA tests and other preventive care tests.

Or, You Can Choose to See Providers Outside the PPO Network

When you need care, you also can decide to see providers who are not in the PPO network. For example, you might stay in-network and see a family practice physician, and go out-of-network to see a specialist. When you do go out-of-network, your expenses are eligible for reimbursement but you're responsible for more of the costs and the benefits will be reduced to the out-of-network level. You are subject to balance billing when you see out-of-network providers.

Note: When a member elects to use both in-network and out-of-network providers, payments made toward deductibles and stop-loss amounts will be applied separately to either the in-network or out-of-network amounts as appropriate. The amounts are different.

Out-of-Network Copayments, Deductibles, and Coinsurance

Deductibles and coinsurance generally apply. The Plan generally pays 60% of the allowed amount after you meet the deductible. You pay 40% of the allowed amount plus you may be required to pay 100% of any amount greater than the usual, customary, or reasonable (UCR) rate or DRG allowed amount—after you meet the deductible.

Preventive Care Coverage Out-of-Network is not available.

An overview showing the new PPO Option benefits and how they compare to the former Standard Option benefits is included on pages 10-14.

THE HIGH OPTION PROVIDES CHOICE—BUT AT A HIGHER COST

Who Can Join

The High Option continues to be available to anyone eligible for SHBP coverage.

Physicians and Other Providers

You are not required to select a primary care physician and you do not need a referral to see specialists. Except for behavioral care and transplants, benefit levels are not based on a provider's network participation. However, when you use a physician who is not in the Participating Physician Program (PPP) (see Glossary) or when you go to a hospital that does not have a direct contract with the SHBP, you are subject to balance billing.

Copayments, Deductibles, and Coinsurance

In most cases, you must meet deductibles before benefits are payable. Most charges are subject to coinsurance. In most cases, the Plan pays 90% of the allowed amount and you pay 10% of the allowed amount after meeting the deductible(s) plus 100% of any charge over the allowed amount from a non-PPP physician or from a hospital that does not have a direct contract with the SHBP.

Preventive Care Coverage

Preventive care is covered up to $100 per person per year for specific tests and immunizations only. There is an additional $75 of coverage for mammograms. No deductible applies. Office visit charges for routine care are excluded from coverage.

MORE INFORMATION ABOUT CONSUMER CHOICE

The PPO Choice Option and the three HMO Consumer Choice Options are the result of a new Georgia law called the Consumer Choice Option Law. This law is effective for SHBP members on July 1, 2000. The law states that if a member joins the Consumer Choice version of an HMO or PPO option, the member can request that an out-of-network provider licensed in Georgia be approved to deliver the member's care on an in-network basis. (Only providers with a valid Georgia medical license may be nominated under the Consumer Choice Option Law, including behavioral health and transplant providers.)

To request that a provider be paid as an in-network provider, the member 'nominates' the provider by filling out a form. (Forms are available by calling the PPO or HMOs.) Providers are not actually added to the network, but the cost to you is the same as seeing an in-network provider. The PPO or HMO must approve the nomination application as long as the provider has appropriate Georgia licensing, agrees to the PPO or HMO terms and conditions for network providers, and accepts the network reimbursement rate.

After the nomination is accepted, the provider can deliver your care and be paid on a network basis for the remainder of the Plan year. For example, if your provider is accepted in August 2000, the nomination is in effect until June 30, 2001. You would then need to renominate them for the July 1, 2001 Plan year.

The premiums for the Consumer Choice Options of the PPO and HMOs are higher than the Standard PPO or regular HMO options, but the benefits, other than the ability to nominate a provider, are identical. You should be aware that if the nominated provider is not accepted by the HMO or PPO or chooses not to agree to your nomination, you cannot change out of the Consumer Choice Option until the following ROCP period unless you have a qualifying event.

A note of caution: A nomination must be completed and approved before care is received. Otherwise, the service is covered at an out-of-network benefit level for PPO members and is not covered for HMO members.

HOW THE PPO OPTIONS COMPARE TO THE FORMER STANDARD OPTION

The following chart is a summary description comparing the major benefits and services of the new PPO Options to the former Standard Option. If you live in an HMO service area, be sure to refer to the *Health Plan Guide for Retirees* to compare the various HMO option benefits.

Standard PPO Option

(Replaces the Standard Option effective July 1, 2000. The following benefits also apply to the PPO Choice Option.)

	In-Network	Out-of-Network	What's Better/Important to Know About the New PPO Option Compared to the Former Standard Option?
Description of Plan	A network of doctors and hospitals that have agreed to offer quality medical care and services at discounted rates with no balance billing.	You can go out-of-network for a lower level of benefit coverage and see any qualified provider. You are subject to balance billing.	If you use PPO network providers, benefit levels are generally higher than under the former Standard Option.
Providers of Service	For the highest benefit, network providers must be used. Prescription drugs may be obtained at any pharmacy. Referrals to specialists are not required.	Any lawfully operated hospital, physician, or other provider of services covered under the plan.	
Maximum Lifetime Benefit	**The Plan Pays:** $2 million	**The Plan Pays:** $2 million	Benefit is $1,000,000 more than the former Standard Option.
Pre-Existing Conditions (1st year in Plan, subject to HIPAA)	$1,000	$1,000	Benefit is the same as the former Standard Option.
Lifetime Benefit for Treatment of:			Benefit is the same as the former Standard Option.
Temporomandibular Joint Dysfunction	$1,100	$1,100	
Substance Abuse	3 episodes	3 episodes	
Organ and Tissue Transplants	$500,000	$500,000	
Home Hyperalimentation	$500,000	$500,000	
Deductibles/ Copayments:	**General Deductible**	**Out-of-Network PPO Deductible**	The in-network deductibles are the same as the former Standard Option. Out-of-Network deductibles are higher than the former Standard Option.
Deductible	$300	$400	
Individual Family Maximum	$900	$1,200	

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Standard PPO Option

Deductibles/ Copayments (Cont.):	In-Network	Out-of-Network	What's Better/Important to Know About the New PPO Option Compared to the Former Standard Option?
Hospital Deductible per admission—excluding BHS and Transplant Program	No separate hospital deductible.	No separate hospital deductible.	There was an additional $100 per admission deductible in the former Standard Option.
BHS and Transplant Program—Hospital Deductible per admission	$100	$100	Benefit is the same as the former Standard Option.
Emergency Room (ER) Copayment	$60; $40 if referred by NurseCall 24; waived if admitted within 24 hours.	$60; $40 if referred by NurseCall 24; waived if admitted within 24 hours.	The copayment is $10 higher than the former Standard Option. The copayment is no longer waived if referred by NurseCall 24 or personal physician, or if outpatient surgery is performed.
Urgent Care Center Copayment	$35	Copayment not applicable. 80% of allowed amount. Subject to deductible.	There was no Urgent Care Center copayment in the former Standard Option. Copayment is less than ER Copayment.
Annual Stop-Loss Limits			In-network stop-loss is $1,000 less than former Standard Option.
Individual (you or one of your dependents)	$1,000	$2,000	
Family (you and your dependents)	$2,000	$4,000	In-network stop-loss is $2,000 less than former Standard Option.
BHS Program (per patient; only applies to BHS-referred care)	$2,500	$2,500	Maximums are the same as they were under the former Standard Option.
Covered Services			
Primary Care Physician or Specialist Office or Clinic Visits: • Treatment of illness or injury • Preventive care	100% after a per visit copayment of $20. Not subject to general deductible.	60% of UCR for treatment of illness or injury, subject to deductible. Preventive care office visits are not covered.	Your costs are lower in-network because coinsurance and deductibles do not apply and preventive care office visits are now covered. Out-of-network, your costs are higher.

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Standard PPO Option

Covered Services (Cont.):	In-Network	Out-of-Network	What's Better/Important to Know About the New PPO Option Compared to the Former Standard Option?
Lab work and tests done in conjunction with preventive care visits including: – Well-newborn exam – Well-child exams and immunizations – Annual physicals – Annual gynecological exams	100% of network rate with no copayment for associated lab work and test charges with a "v" (routine) code, up to a maximum of $500 per year per person (at network rate.) Not subject to general deductible. Covered according to age schedules and medical history. Look up age schedules online at www.healthygeorgia.com or call member services line at 800-483-6983 (outside Atlanta) or 404-233-4479 (inside Atlanta).	Not covered. Charges do not apply to deductible or annual stop-loss limits.	In-network benefits are significantly richer than in the former Standard Option—office visit charges are covered and you receive up to $400 more benefit coverage for lab work and tests.
Lab work and tests done in conjunction with treatment of illness or injury including (pre-certification may be required): – x-ray – allergy testing – injectible medications	90% of network rate. Subject to general deductible.	60% of UCR. Subject to deductible.	Your benefit level is 10% higher in-network than under the former Standard Option.
Maternity Treatment (prenatal, delivery, and postnatal)	90% of network rate after an initial visit copayment of $20. No copayments for subsequent visits. Not subject to general deductible.	60% of UCR. Subject to deductible.	Your benefit level is 10% higher in-network than under the former Standard Option.
Outpatient Surgery in an office setting	90% of network rate. Subject to general deductible.	60% of UCR. Subject to deductible.	Your benefit level is 10% higher in-network than the former Standard Option. Charges are subject to general deductibles.
Allergy Shots and Serum	100% for shots and serum. (If physician is seen, visit is treated as an office visit subject to the per visit copayment of $20.) Not subject to the general deductible.	60% of UCR. Subject to deductible	Your out-of-pocket costs are lower in-network because coinsurance and deductibles do not apply.
Physician Services Furnished in a Hospital •Surgery (including charges by Surgeon, Anesthesiologist, Pathologist, Radiologist, and consultation)	90% of network rate. Subject to general deductible.	60% of UCR. Subject to deductible.	Your benefit level is 10% higher in-network than under the former Standard Option. Charges are now subject to general deductible.

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Standard PPO Option

Covered Services (Cont.):	In-Network	Out-of-Network	What's Better/Important to Know About the New PPO Option Compared to the Former Standard Option?
• Well-newborn care	100% of network rate.	Not covered.	Not covered under the former Standard Option.
Outpatient Surgery Facility Hospital or Ambulatory Surgical Center	90% of network rate. Subject to general deductible.	60% of UCR. Subject to deductible.	Your benefit level is 10% lower in-network than it was under the former Standard Option. Charges are now subject to general deductible.
Hospital Services Other Than Those for Emergency Room Care and Outpatient Surgery • Inpatient Care (including inpatient short-term rehabilitation services.) Precertification required.	90% of network rate. Subject to general deductible.	60% of UCR. Subject to deductible.	Your benefit level is 10% higher in-network than under the former Standard Option.
• Outpatient Services	90% of network rate. Subject to general deductible.	60% of UCR. Subject to deductible.	Your benefit level is 10% lower in-network than under the former Standard Option.
Care in a Hospital Emergency Room for Treatment of an Emergency Medical Condition or Injury	90% of network rate after a per visit copayment of $60. The copayment is reduced to $40 if referred by NurseCall 24. The copayment is not charged if admitted within 24 hours. General deductible applies.	60% of allowed amount after a per visit copayment of $60. The copayment is reduced to $40 if referred by NurseCall 24. The copayment is not charged if admitted within 24 hours. Deductible applies.	Your benefit level is 10% higher in-network than the former Standard Option. If admitted, you no longer have to pay a separate hospital deductible. The emergency room copayment is waived only if admitted.
Urgent Care Centers *(In an approved urgent-care center; see PPO Provider Directory)*	100% of network rate after a per visit copayment of $35. Not subject to a general deductible.	80% of UCR. Subject to deductible.	Your out-of-pocket costs are lower in-network because coinsurance and deductibles do not apply.
X-rays and Laboratory Services *(From an approved provider)*	90% of network rate. Subject to general deductible.	60% of UCR. Subject to general deductible.	Your benefit level is 10% higher in-network than under the former Standard Option.
Skilled Nursing Facility Services	Not covered.	Not covered.	Benefit is the same as the former Standard Option.
Home Nursing Care *(Limited to $7,500 per year; Plan-approved Letter of Medical Necessity required. If in lieu of hospitalization, additional benefits may be approved.)*	90% of network rate. (Two hours of care in a 24-hour day.) Subject to general deductible. Expenses do not apply to annual stop-loss limit.	60% of UCR. (Two hours of care in a 24-hour day.) Subject to general deductible. Expenses do not apply to annual stop-loss limit.	Your benefit level is 10% higher in-network than the former Standard Option.

Continued on page 14

Standard PPO Option

Covered Services (Cont.):	In-Network	Out-of-Network	What's Better/Important to Know About the New PPO Option Compared to the Former Standard Option?
• Home hyperalimentation (Must be precertified; lifetime benefit limit of $500,000)	90% of network rate. Subject to general deductible.	60% of UCR. Subject to deductible.	Your benefit level is 10% higher in-network than the former Standard Option.
Hospice Care *(Precertification required; if in lieu of hospitalization, additional benefits may be approved.)*	100% of network rate. Subject to general deductible.	60% of UCR. Subject to deductible.	Your benefit level is 10% higher in-network than the former Standard Option.
Ambulance Services	90% of network rate. Subject to general deductible. Medically necessary emergency transportation only.	60% of UCR if medically necessary, non-emergency transportation, or if not MCP approved. Subject to deductible.	Your benefit level is 10% higher in-network than the former Standard Option.
Durable Medical Equipment (*May Require Plan-approved Letter of Medical Necessity)*	90% of network rate. Subject to general deductible.	60% of allowed amount. Subject to deductible.	
Outpatient Short-Term Rehabilitation Services (Physical, Speech, Cardiac, and Occupational therapies are each limited to 40 visits per year)	90% of network rate. Subject to general deductible.	60% of UCR. Subject to deductible.	Your benefit level is 10% higher in-network than under the former Standard Option. Annual visit limitations and lifetime TMJ benefits are the same as the former Standard Option.
Treatment of TMJ Diagnostic testing and non-surgical treatment limited to $1,100 lifetime maximum	90% of network rate. Subject to general deductible.	60% of UCR. Subject to general deductible.	
Chiropractic Care *(Limited to 40 visits per year)*	90% of network rate. Subject to general deductible.	60% of allowed amount. Subject to deductible.	

Important Note: Payments for covered services from an in-network PPO provider will apply only to the in-network deductible and stop-loss amounts. When a member uses both in-network and out-of-network providers, payments made toward deductibles and stop-loss amounts will be applied separately to the appropriate in-network or out-of-network amounts. Annual dollar and visit limitations are based on a July 1 to June 30 fiscal year.

Note: See page 17–19 for information on prescription drug, BHS, and transplant benefits.

HOW THE PPO OPTIONS COMPARE TO THE HIGH OPTION

Following are some of the major points to consider between the new Standard PPO Option and PPO Choice Option and the High Option. Before making a decision, you should carefully compare the benefits and costs of all the available options.

Benefits and Services	What's Better/Important to Know About the New PPO Options?
Premiums	Premiums for the PPO Choice Option are lower than for the High Option. Premiums for the Standard PPO Option are significantly lower than for the High Option.
Deductibles and Coinsurance	The general deductible is the same in both the PPO options and the High Option. The out-of-network PPO deductible is $100 more per person and $300 more per family. Under the PPO Options, you do not have to meet a separate hospital deductible. Coinsurance for the Standard PPO and PPO Choice Options in-network is generally 10%—the same as coinsurance for the High Option. Out-of-network, PPO Option coinsurance is 40%.
Stop-Loss Limits	Under the PPO Options, your in-network stop-loss limits are $500 less for individuals and $500 less for families than they are under the High Option.
Preventive Care	Preventive care benefits are much richer under the PPO Options, in-network, than under the High Option. — In-network under the PPO Options, you pay a $20 copayment for office visits and receive a 100% benefit for associated lab work and tests up to a maximum of $500 per person per benefit year. Preventive care is not covered out-of-network. — Under the High Option, your maximum preventive care benefit is $100 per person per year for certain tests and immunizations and an additional $75 per year for routine mammograms. Office visits for preventive care are not covered.
Office Visits for Illness or Injury	Your costs for illness or injury office visits are generally much lower in-network under the PPO Options than under the High Option. — When you get care in the PPO network, you pay a $20 copayment for physician or clinic visits , no deductible applies, and you are not subject to balance billing. For associated lab work and tests, you pay 10% coinsurance, subject to the general deductible. Out-of-network, you pay 40% of allowed charges after meeting a $400 deductible, and you are subject to balance billing. — In the High Option, generally you pay 10% of allowed charges after meeting a $300 deductible and if you do not use a PPP physician, you are subject to balance billing.

HOW YOUR OUT-OF-POCKET COSTS COMPARE

Following are some common situations when care is needed along with comparisons of your out-of-pocket costs when you get care in one of the PPO Options, in the High Option, and in the former Standard Option.

As described in the examples below, your level of benefit coverage under the PPO Options in-network is generally 10% higher than under the former Standard Option and the same as the High Option. But the PPO saves you even more money because no deductibles or coinsurance apply to office visits when you see participating network providers. You only pay a $20 copayment for the office visit. (Associated lab work and tests for an illness or injury are covered at 90%, subject to the general deductible.)

Also, in-network under the PPO, lab work and tests done in conjunction with a preventive care office are covered at 100% up to a maximum per person per year benefit of $500 and no deductible applies. That's $400 more than the level of preventive care benefit coverage in either the former Standard Option or in the High Option.

Finally, even though your in-network PPO general deductible is the same as it is in High Option and in the former Standard Option, there is no additional per admission hospital deductible in the PPO Option (except for BHS and transplant admissions). However, you should be aware that there are separate deductibles in-network and out-of-network and that deductibles and coinsurance payments accumulate separately for in-network and out-of-network care.

COMMON CARE SITUATIONS

1. You're ill and visit a physician in the office.

- Under the Standard PPO Option and PPO Choice Option, you pay a $20 copayment for in-network care. And that's all. You are protected from balance billing and you do not have to meet a deductible first. Out-of-network, you pay 40% coinsurance after meeting the $400 deductible.*
- Under the former Standard Option, you paid 20% coinsurance after you met the $300 general deductible.
- Under the High Option, you pay 10% coinsurance after you meet the $300 general deductible.*

2. You need an immunization or lab work in conjunction with a preventive care office visit.

- Under the Standard PPO Option and PPO Choice Option, you pay nothing when you see a participating network provider—up to a maximum benefit of $500 per year for associated lab and test charges. Preventive care is covered according to age schedules and medical history. Office visits are covered with a copayment. Out-of-network, immunizations and lab work for preventive care are not covered.
- Under the former Standard Option, you paid nothing up to a maximum benefit of only $100 per year and the cost of the office visit was not covered.
- Under the High Option, you pay nothing up to a maximum benefit of only $100 per year and the cost of the office visit is not covered.

3. You're admitted to a hospital.

- In network, under the Standard PPO Option and PPO Choice Option, you pay 10% of the allowed amount after you meet the $300 general deductible and you are protected from balance billing. Out-of-network, you pay 40% of the allowed amount after you meet the $400 deductible.* There is no additional hospital deductible.
- Under the former Standard Option, you paid 20% of the allowed amount of the institutional charge after meeting the $100 per admission deductible.
- Under the High Option, you pay 10% of the allowed amount of the institutional charges after meeting the $100 per admission deductible.*

4. You get a prescription filled.

- Under the Standard PPO Option and PPO Choice Option you pay 10% of the allowed amount after you meet the $300 general deductible. (You are subject to balance billing if you use a non-network pharmacy.)
- Under the former Standard Option, you paid 20% of the allowed amount after meeting the $300 general deductible.
- Under the High Option, you pay 10% of the allowed amount after meeting the $300 general deductible, the same as you pay under the PPO Options. However, your monthly premium is much higher than the PPO Options.

**Note: You are subject to balance billing if charges exceed the Plan's allowed amounts.*

HOW THE PPO NETWORK PROVIDER WAS SELECTED

The Georgia Department of Community Health selected the combined resources of The Medical Resource Network, LLC (MRN) and Georgia 1st, Inc. to provide network management services for the PPO Option. The selection was based on overall quality, access,

and to a lesser extent, cost. This joint venture includes more than 8,500 physicians, 151 hospitals, and a comprehensive chiropractic and ancillary network (ancillary providers include durable medical equipment vendors, independent labs, home health agencies, and others.)

The PPO network was required to meet the following qualifications:

- The PPO network must continuously monitor the quality of care provided by participating physicians, hospitals, and other providers;
- The PPO network must require and verify the existence and maintenance of credentials, licenses, certificates, and insurance of all the providers. The credentials must be verified every two years; and
- Each PPO network physician must possess and maintain admitting privileges at a minimum of one PPO hospital unless the PPO has requested in writing that the PPO physician does not maintain admitting privileges.

WHAT'S NOT CHANGING

Many existing health care relationships are not changing. Administrative functions and requirements that were common to the Standard and High Options will continue under the PPO Options. For example:

Medical Certification Program (MCP)—The MCP program is not changing. The program is designed to help members and the Plan save money by preventing unnecessary care. To avoid a reduction in benefits, you must comply with the MCP requirements outlined in the Plan booklet. Although procedures have not changed, there are some changes to the list of outpatient procedures that require precertification. See pages 22-23 for more information on these changes.

Claims Processing—The SHBP uses the same claims processor used for both the High and former Standard Options. The claims procedures for the PPO Options are the same as they were under the High and former Standard Options.

NurseCall 24 Program—This program will continue to be available 7 days a week, 24 hours a day to answer health-related questions, to mail you literature, and assist PPO and High Option members in determining the most appropriate level of care when medical attention is requested. If you are referred to an emergency room by NurseCall 24, your ER copayment is reduced from $60 to $40.

Participating Physician Program (PPP)—The PPP will continue to protect High Option members against balance billing. The PPP is a contractual arrangement between the Plan's claims administrator and medical doctors in Georgia. Each participating physician agrees to accept the Plan's allowed amount for his or her services and may not balance bill members for charges other than the coinsurance and non-covered services amounts. PPO members also are protected from balance billing when they use providers in the PPO network.

Appeals Process—The appeals process under the PPO Options is the same as it was under the High Option and the former Standard Option.

Exclusions—No new exclusions have been added. The exclusions under the PPO Options are the same as they were under the former Standard Option and are under the High Option.

A Special Note on Separate Provider Networks

The network of participating PPO providers does not include pharmacies, BHS providers, or transplant providers. A separate network of providers is in place for each benefit program. PPO Option and High Option members will continue to have access to these same networks without change. The following is a brief description of how each benefit program will continue to work under the PPO and High Options. See the chart on page 19 for more information on these special benefit programs.

Prescription Drug Program—The new PPO network does not change how you use the existing pharmacy network. You may continue to use the same pharmacies as in the past with your prescriptions covered at 90% of the network rate, regardless of whether you are a PPO or High Option member. (For former Standard Option members this is a 10% higher level of benefit coverage.) All the major pharmacy chains and most independent pharmacies throughout the state are participating in the pharmacy network. Although you still receive a 90% benefit if you use a non-network pharmacy, you are subject to balance billing for any prescription charges that exceed the pharmacy network rate.

You also should be aware that the penalty for brand-name drugs will remain in effect. For a brand-name drug (if a generic equivalent is available and if neither the physician nor the pharmacist has specified a brand name), the benefit is either the average network-reimbursable generic amount or half of the network-reimbursable brand-name amount—whichever is more.

Behavioral Health Services (BHS) Program—The new PPO network does not change how you use the existing network of BHS providers or the level of benefit coverage that you receive under the BHS Program, regardless of whether you are a PPO or High Option member. BHS will provide mental health and substance abuse referrals for PPO and High Option members. The level of benefit you receive is based on whether or not you receive a BHS referral for care. To receive the highest level of benefit coverage, PPO and High option members must receive a referral from the BHS program prior to receiving services.

Transplant Program—The new PPO network does not change how you use the existing network of contracted transplant centers. You continue to have access to contracted transplant centers as in the past with MCP-approved transplants covered at 90% of the network rate, regardless of whether you are a PPO or High Option member. (For former Standard Option members this is a 10% higher level of benefit coverage.) The MCP will provide prior approvals for transplants for PPO and High Option members. The level of benefit you receive is based on whether you use a contracted or non-contracted transplant center. To receive the highest level of benefit coverage, PPO and High option members must receive prior approval through the MCP and use a contracted transplant center.

HOW SPECIAL BENEFIT PROGRAMS WILL WORK

Note that the information contained in the following table is a summary to give you an overview only of how your coverage works in the special cases where benefit programs have their own separate network of participating providers. Benefit limitations, precertification requirements, and other details are not listed in the table. Please refer to your SHBP booklet dated November 1, 1995 and to subsequent UPDATERs for additional details.

PPO/High Option Benefit Program	What determines whether I receive the higher or lower level of benefit coverage?	What is the higher level of benefit coverage?	What is the lower level of benefit coverage?	How are my out-of-pocket expenses applied to deductibles and stop-loss limits?
Prescription Drug Program	Benefit coverage is a fixed percentage.	Although the level of benefit coverage is fixed at 90% of the network rate, you are not subject to balance billing if you use a participating network pharmacy.	If you use a non-network pharmacy and are charged more than 90% of the network rate, you are responsible for the 10% coinsurance amount and the amount charged over the network rate.	To the $300 general deductible; and To the $1,000 stop-loss limit under the PPO options; or To the $1,500 stop-loss limit under the High Option
BHS Program	Whether or not your care is referred by BHS. BHS referred care has a higher level of benefit coverage.	90% of the network rate for facility charges. 80% of the network rate for professional charges.	60% of the network rate for facility charges. 50% of the network rate for professional charges.	To the $300 general deductible for professional charges and, if in High Option, to the $100 deductible for hospital charges; and For BHS referred care, to the separate $2,500 stop-loss limit; there is no stop-loss limit for non-referred care.
Transplant Program	Whether or not you receive care at a contracted transplant center. Care received at a contracted center has a higher level of benefit coverage. (Contact the MCP prior to any transplant care.)	90% of the network rate.	60% of the network rate.	To the $300 general deductible for professional charges and, if in High Option, to the $100 deductible for hospital charges; and To the $1,000 stop-loss limit under the PPO options; or To the $1,500 stop-loss limit under the High Option.

PPO SERVICE AREA

You must live or work in the following zip codes to be eligible for the PPO Options.

Alabama

35901	36855
35903	36856
35904	36859
35959	36863
35960	36867
35961	36868
35967	36869
35973	36870
35983	36872
36262	36874
36263	36875
36264	36877
36269	
36272	
36273	
36274	
36275	
36301	
36302	
36303	
36304	
36305	
36312	
36313	
36319	
36320	
36321	
36322	
36345	
36349	
36350	
36352	
36353	
36370	
36371	
36375	
36376	
36804	
36851	
36854	

Florida

32004	32224	32304
32009	32225	32306
32011	32226	32307
32030	32227	32308
32034	32228	32309
32035	32229	32310
32041	32230	32311
32046	32231	32312
32050	32232	32313
32065	32233	32314
32067	32234	32315
32068	32235	32316
32073	32236	32317
32082	32237	32324
32095	32238	32330
32097	32239	32332
32099	32240	32333
32200	32241	32337
32201	32244	32343
32202	32245	32344
32203	32246	32345
32204	32247	32350
32205	32250	32351
32206	32254	32352
32207	32255	32353
32208	32256	32361
32209	32257	32362
32210	32258	32395
32211	32259	32399
32212	32260	32423
32214	32266	32426
32215	32267	32432
32216	32276	32440
32217	32277	32442
32218	32294	32443
32219	32296	32447
32220	32297	32448
32221	32301	32460
32222	32302	33900
32223	32303	

Georgia

The PPO Options are available in all Georgia zip codes.

South Carolina

29003	29804	29904
29042	29805	29905
29081	29808	29906
29105	29809	29910
29113	29810	29915
29129	29812	29918
29137	29813	29920
29138	29814	29922
29146	29816	29925
29166	29817	29926
29621	29821	29927
29622	29822	29928
29623	29824	29931
29624	29826	29934
29625	29827	29935
29626	29828	29938
29628	29829	29939
29639	29831	29940
29643	29832	29943
29655	29834	29948
29656	29836	
29658	29838	
29659	29839	
29664	29841	
29665	29842	
29666	29843	
29672	29844	
29675	29845	
29677	29846	
29678	29847	
29679	29849	
29684	29850	
29686	29851	
29689	29853	
29691	29856	
29693	29860	
29696	29861	
29801	29901	
29802	29902	
29803	29903	

Tennessee

37302	37406
37304	37407
37307	37408
37308	37409
37309	37410
37310	37411
37311	37412
37312	37414
37315	37415
37316	37416
37320	37419
37323	37421
37325	37422
37336	37424
37338	37450
37340	37499
37341	
37343	
37347	
37350	
37351	
37353	
37361	
37362	
37363	
37364	
37369	
37370	
37373	
37377	
37379	
37384	
37396	
37397	
37400	
37401	
37402	
37403	
37404	
37405	

HIGH OPTION SERVICE AREA

Unrestricted. Anyone eligible for SHBP coverage may enroll.

HMO SERVICE AREAS

See the *Health Plan Decision Guide for Retirees* included in this package.

A REVIEW OF HIGH OPTION BENEFIT CHANGES

In addition to a premium increase, there are High Option benefit changes. This chart summarizes those changes.

High Option Benefit Changes

Benefit	High Option Benefits Effective July 1, 2000	High Option Benefits Prior to July 1, 2000	What's Different?
Lifetime Maximum Benefit	$2,000,000	$1,000,000	Maximum benefit increased by $1,000,000.
Emergency Room Services	$60 copayment; $40 copayment if referred by NurseCall 24. Fully waived if admitted.	$50 copayment; fully waived if admitted or referred by NurseCall 24 or physician or if outpatient surgery was performed.	Emergency room copayment increased by $10. Fully waived only if admitted. $20 copayment reduction if referred by NurseCall 24.
Home Nursing Care	Two hours of home care per day by RN or LPN, if medically necessary and ordered by a physician—up to $7,500 per year—are covered at 90% of the UCR after the general deductible is met.	Two hours of home care per day by RN or LPN, if medically necessary and ordered by a physician—up to $7,500 per year—were covered at 80% of the UCR after the general deductible was met.	Your level of benefit coverage increased by 10%.
Stop-Loss Limits	Stop-loss protection limits the deductibles and coinsurance to $1,500 of eligible out-of-pocket expenses per person, or $2,500 per family per Plan year	Stop-loss protection limited the deductibles and coinsurance to $1,000 of eligible out-of-pocket expenses per person or $2,000 per family, per Plan year.	You pay up to $500 more for both individual and family coverage before your stop-loss protection limits apply.
Surgery • Physician services	Professional fees are subject to the general deductible.	Payment for professional fees was not subject to the general deductible.	Professional fees now subject to the general deductible.
• Outpatient facility or ambulatory surgical center charges	90% of allowed amount, subject to general deductible.	100% of allowed amount, and not subject to deductible.	Benefit level is now 10% lower and subject to general deductible.
Out-of-state hospitals	90% of DRG allowed amount after meeting the $100 deductible. Subject to balance billing.	90% of charge after meeting the $100 deductible. Not subject to balance billing.	Charges now subject to DRG maximums and to balance billing.

For premium information, see the enclosed Rate Worksheet.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Each year, the Georgia Department of Community Health is required to notify you of the federal law known as the Women's Health and Cancer Rights Act of 1998. The Act generally requires those group health plans and insurance companies that provide mastectomy-related benefits or services to provide specific coverages to Plan participants or beneficiaries.

The Act provides a group health plan participant or beneficiary who is receiving benefits in connection with a mastectomy, and who elects breast reconstruction in connection with the mastectomy, with coverage for the following:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas.

Coverage for these benefits or services will be provided in a manner determined in consultation with the attending physician and the patient.

Coverage for the mastectomy-related services or benefits provided under the Act will be subject to the same deductibles and coinsurance provisions that apply to other medical or surgical benefits provided under the SHBP.

High Option

For the High Option, medical care services generally require a $100 inpatient hospital deductible (per confinement), and 10% coinsurance on hospital charges, up to the member's stop-loss limit.

PPO Option

For the PPO Option, in-network, medical care services typically require a 10% coinsurance after the general deductible of $300 per person/$900 per family is met. Out of the PPO network, a 40% coinsurance and $400 per person/$1,200 per family deductible apply.

If you are a covered member or qualified dependent under the SHBP, and you require a mastectomy, the Plan's coverage includes all treatments for which coverage is required under the Women's Health and Cancer Rights Act.

MCP OUTPATIENT PRECERTIFICATION CHANGES

Effective July 1, 2000, the outpatient precertification list last published in the Spring/Summer 1998 *UPDATER* will be replaced with the list given below. Esophageal surgery is a new category requiring precertification. There also are a number of laparoscopy CPT codes that are added or deleted. All new procedure codes are shown in bold italics. Changed codes are in italics.

CAT or CT Scans (except for brain and spine):
70480 through 70492; 71250 through 71270; 72192 through 72194; 73200 through 73202; 73700 through 73702; 74150 through 74170; 76375; 76380.

Colonoscopies:
45378 through 45385.

Endoscopies:
43234; 43235; 43239.

Esophageal Surgeries:
43280; 43289; 43324; 43325.

Laparoscopies and/or Peritoneoscopies:
47562; 47563; 47564; 49320; 49321; 49322; ***49329****; 58550; 58551;* ***58578****;* ***58579****; 58660; 58661; 58662;* ***58679***.

MRAs:
70541; 71555; 72159; 72198; 73225; 73725; 74185.

MRIs:
70336; 70540; 70551 through 70553; 71550; 72141 through 72158; 72196; 73220; 73221; 73720; 73721; 74181; 75552 through 75556; 76093; 76094; 76400.

Nasal Surgeries:
30130; 30140; 30400 through 30520; 30620; 30801; 30802; 30930.

Sleep Studies:
95805; 95806; 95807; 95808; 95810; 95811.

Uvulopalatopharyngoplasties:
42120; 42140; 42145; 42299; 42950.

You may want to share this list with your physician. If either you or a covered dependent plans to undergo one of the listed procedures, call the Medical Certification Program in advance for precertification. The toll-free number outside of the Atlanta area is (800) 762-4535, and the number in the Atlanta area is (770) 438-9770.

SHBP BALANCE BILLING POLICY AND RELATED ISSUES

EFFECTIVE JULY 1, 2000—

High Option

Out-of-state hospital charges under the High Option will be subject to balance billing. After meeting your $100 deductible, the High Option will pay 90% of a DRG allowed amount. You will be responsible for the 10% coinsurance amount plus all charges that exceed the DRG allowed amount, if any.

You will continue to be subject to balance billing from out-of-state and non-PPP providers.

PPO Options

If you use participating network providers, you are protected from balance billing. Also note that the PPO network includes participating network providers in selected out-of-state areas, including areas near the Georgia border in Alabama, Florida, South Carolina, and Tennessee. (Please refer to the enclosed PPO Provider Directory. You can also access the PPO Provider Directory online at www.communityhealth.state.ga.us.)

Out-of-network hospital charges for routine or planned care under the PPO options are subject to balance billing. After meeting your $400 deductible, the PPO options pay 60% of a DRG allowed amount. You are responsible for the 40% coinsurance amount plus all charges that exceed the DRG allowed amount, if any. However, for emergency or acute care out-of-network, the PPO pays 90% of the DRG amount after meeting the $300 general deductible, subject to the possibility of balance billing. (See the Glossary for emergency and acute care definitions.)

Out-of-network professional charges for routine or planned care under the PPO options are subject to balance billing. After meeting your $400 deductible, the PPO options pay 60% of a UCR allowed amount. You are responsible for the 40% coinsurance amount plus all charges that exceed the UCR allowed amount, if any. However, for emergency or acute care out-of-network, the PPO options pay 90% of the UCR amount after meeting the $300 general deductible, subject to the possibility of balance billing.

Stop-Loss Limits

Charges that exceed the Plan's allowed amounts are not applied toward deductibles or stop-loss limits, regardless of your coverage option.

VISION DISCOUNT PROGRAM

(See the Spring/Summer 1997 UPDATER for program information.)

The BlueChoice Vision discount program will be a feature of the new Standard PPO and PPO Choice Options.

If you are a High Option member, the discount program will remain in effect until further notice.

HIPAA ANNUAL NOTICE

Each year the Plan is required to notify you of certain rights available to you under the Health Insurance Portability and Accountability Act.

The PPO and High options contain a pre-existing conditions limitation. Specifically, the Health Plan will not pay charges that are over $1,000 for the treatment of any pre-existing condition (see Glossary) during the first 12 months of a patient's coverage, unless the patient gives satisfactory documentation that he or she has been free of treatment for at least six consecutive calendar months.

In certain situations, SHBP members and dependents can reduce the 12-month pre-existing condition (PEC) limitation period. The reduction is possible by using what is called "creditable coverage." Creditable coverage generally includes the health coverage you or a family member had immediately prior to joining the SHBP. Most group health plans, including individual health policies and governmental health programs qualify as creditable coverage.

For Individuals Gaining SHBP Coverage

The PEC limitation period can be reduced by the length of time that creditable coverage existed, under the following conditions:

- When the Plan member provides the SHBP with a certificate of creditable coverage from one or more former health plans that states when coverage started and ended for each covered person under that plan who now desires SHBP coverage; and

For Members

- When the time between losing coverage under the most recent former health plan and the later of either your hire date (with the state or school system) or the first day of the waiting period prior to SHBP coverage does not exceed 63 days.

For Eligible Dependents (including spouses)

- When the time between the day your dependent becomes covered under the SHBP and the last day your dependent had coverage from any former health plan does not exceed 63 days.

Note: If you or a dependent (including a spouse) had any break in former coverage lasting more than 63 days, you or your dependent will receive coverage only for the period of time after the break ended.

You have the right to obtain a letter of creditable coverage from your former employer(s) to offset the PEC limitation period under the SHBP. If you require assistance in obtaining a letter from a former employer, contact the Plan's eligibility unit at 404-656-6322 in the Atlanta area or at 800-610-1863 outside the Atlanta area.

GLOSSARY

Acute Care
Care provided when such services are medically necessary and immediately required as a result of a sudden onset of illness or injury.

Allowed Amount
A dollar figure the Plan uses to calculate benefits payable. In many cases, the allowed amount equals a usual, customary, or reasonable (UCR) amount (see UCR definition). In the case of hospitals, the allowed amount is based on a patient's diagnosis. See DRG definition. Plan members using non-network providers (PPO Option) or non-participating providers (High Option) are responsible for paying any amount charged over the allowed amount. PPO members using network providers are charged only up to the allowable amount and will not be subject to additional payments for that service.

Balance Billing
A dollar amount charged by a provider that is over the Plan's allowed amount for the care or treatment received. Amounts balance billed are the member's responsibility and do not apply to the Plan's stop-loss limits. PPO providers do not bill for amounts over the allowed amount and, thus, members will not be subject to balance billing when using a network PPO provider.

Behavioral Health Services (BHS)
The BHS program is part of the PPO and High Options. It is a managed care program for mental health and substance abuse benefits. The program is designed to provide wide access to necessary care while balancing choice of provider, enhanced benefits within the network, and overall cost effectiveness. In order to receive full benefits, members must contact BHS prior to receiving behavioral health services.

Coinsurance
A percentage of the provider's charge or the Plan's allowed amount that must be paid by the member, generally 10% to 40%.

Copayment
A fixed dollar amount that must be paid by the member for a particular service or item, for example, $10 or $20 for office visits.

Deductible
A fixed dollar amount that must be paid out-of-pocket by the patient before any benefit is payable by the patient's health care plan. Paid each Plan year and, in some cases, paid per hospital admission, depending on your coverage option.

DRG
Diagnostic related group. For charges from in-state hospitals that contract directly with the State Health Benefit Plan (SHBP), the Plan pays a fixed amount based on the patient's diagnosis. The actual diagnosis is converted into a DRG that is used to calculate the hospital's reimbursement. Contracting hospitals agree to accept the DRG amount as the allowed amount.

Emergency Care
Care provided in the event of a sudden, severe, and unexpected illness or injury which, if not treated immediately, could be life-threatening or result in permanent impairment of bodily functions.

Indemnity Plan
A health plan model allowing members the most freedom to select providers and to direct their own care. The High Option is an indemnity-type plan.

Medical Certification Program (MCP)
The MCP is a part of the PPO and High Options. It is designed to help members and the Plan save money by preventing unnecessary care. To avoid a reduction in benefits, you must comply with the MCP requirements outlined in the Plan booklet.

Participating Physician Program (PPP)
A contractual arrangement between the Plan's claims administrator, Blue Cross Blue Shield of Georgia, Inc., and medical doctors who practice in Georgia.

Each participating physician agrees to accept the Plan's allowed amount for his or her services and may not balance bill members. PPP applies to the High Option. (Participating PPO providers also agree to accept the Plan's allowed amount and may not balance bill members.)

Plan Year
July 1st through June 30th of the following year.

Pre-Existing Condition (PEC)
Existence of a condition or symptoms which would cause an ordinarily prudent person to seek diagnosis, care, or treatment; or of a condition for which medical advice or treatment (including medication) had been recommended by or received from any health care provider before SHBP coverage began. The period subject to review for PECs is six months, beginning from the later of either your hire date or the first day of the waiting period prior to coverage under the Plan.

Preferred Provider Organization (PPO)
The PPO is a comprehensive network of doctors, ancillary providers, and hospitals that have agreed to offer quality medical care and services at discounted rates. You must use a network provider to receive the highest level of coverage. If you choose a PPO, you have the flexibility to go out-of-network for your health care services but you will receive a reduced level of benefit. With you out-of-network benefits, you can see any qualified provider of medical services. You pay a greater percentage of the charges for covered services if you go out-of-network and you are subject to balance billing for charges above the Plan's allowed amount.

Primary Care Physician (PCP)
A doctor who has the primary responsibility for providing, arranging, and coordinating every aspect of a patient's health care. An HMO member must select a PCP. A member of a PPO may choose to have a PCP, but it is not required. Generally, PCPs are either internists, family practitioners, pediatricians, or OB/GYNs.

Provider
Licensed medical doctors, hospitals, and other health care providers through whom the Plan offers coverage.

Self-Insured Benefit Plan
A program of medical care reimbursement in which an employer and its employees pay all costs of employee health care; no outside insurance company underwrites the risk or makes a profit. The High Option and PPO Options are self-insured benefit plans.

Service Area
A service area consists of approved counties or zip codes in which in-network services are available.

Stop-Loss Limit
A maximum annual dollar amount that a Plan member would have to pay out-of-pocket for covered expenses. Once the stop-loss limit is reached, covered expenses for the remainder of the Plan Year are reimbursed at 100%. Stop-loss limits apply per person and per family.

Usual, Customary, and Reasonable (UCR)
UCR fees apply to High Option members and to PPO Option members who choose to go out-of-network. PPO members who choose to go in-network are subject to a maximum allowed amount, not to a UCR fee. Participating PPO providers do not bill for amounts over the discounted rate. The UCR fee may be defined in three parts:

—**Usual Fee**
The fee a physician most frequently received as reimbursement for the procedure performed.

—**Customary Fee**
The fee based on a competitive profile of the usual fees received as reimbursement by similar physicians in a given geographic area for the procedure performed, according to third-party administrator's records.

—**Reasonable Fee**
The fee different from a usual or customary fee because of unusual circumstances involving complications requiring additional time, skill, and experience.

The Plan pays up to the usual fee, not to exceed the customary fee, unless special circumstances or complications occur, in which case the Plan may consider the reasonable fee.

FOR MORE INFORMATION

HMO Options

If you are eligible for HMO option coverage, benefit information is in the enclosed *Health Plan Benefit Guide for Retirees* or by calling the HMO directly:

- Aetna US Healthcare: (800) 444-0759
- Aetna US Healthcare Consumer Choice: (800) 443-6917
- Aetna US Healthcare Medicare+Choice: 1-888-217-2768
- Aetna US Healthcare Web site: **www.aetnaushc.com**
- BlueChoice: (800) 464-1367
- BlueChoice Consumer Choice: (800) 464-1367
- BlueChoice Medicare+Choice: (800) 652-7189

  Hearing impaired: (877) 463-2187
- BlueChoice Web site: **www.bcbsga.com**
- Kaiser Permanente: (404) 261-2590
- Kaiser Permanente Consumer Choice: (404) 261-2590
- Kaiser Medicare+Choice: (800) 956-1358
- Kaiser Permanente Web site: **www.kp.org/ga**

PPO Options

During the ROEP, call volume may be very high, and you may experience time on hold or be asked to dial another number.

Retiree Help Line: (800) 230-2291

TDD line for the hearing impaired: (404) 842-8073

New Patient Availability and Status of Pending Participating Network Providers Information: (800) 675-6492

On-Line PPO Provider Directory:
www.communityhealth.state.ga.us

For on-line viewing of preventive care health standards, visit the MRN/GA 1st web site at **www.healthygeorgia.com** (schedule applies to PPO Option members using in-network providers.)

For PPO Choice Option members
Only providers with a valid Georgia license may be nominated under the Consumer Choice Option Law.

Nomination of PPO Provider Information: (800) 675-6492

Nomination of BHS Provider information: (800) 631-9943
(404) 842-8073 (TDD Line for the hearing impaired)

Nomination of Transplant Provider Information:
(770) 438-9770 (Atlanta area)
(800) 762-4535 (outside Atlanta)
(800) 453-9776 (TDD Line for the hearing impaired)

High Option

- Retiree Help Line: 1-800-230-2291 (Available from April 3, 2000 through May 16, 2000)
- TDD line for the hearing impaired: (404) 842-8073

For PPO and High Option members
For emergency room referrals and for medical information from registered nurses 24-hours a day, seven days a week, call NurseCall 24: (800) 524-7130

For More about Medicare or Your Insurance Premiums

To find out more about your Medicare premiums, Social Security benefits, applying for Medicare or to locate the Social Security office nearest you, call:

- Social Security Administration
  - —Toll free: (800) 772-1213
  - —The Social Security Administration: www.ssa.gov

If You Have Access to the Internet, Visit the Web Site to Change Your Option

- The State Health Benefit Plan: www.statehealth.org
  - —If you want to make changes to your SHBP coverage, you can do so on line at our new Web site. If you decide to change your health coverage option, you can visit www.statehealth.org between April 17, 2000 and May 16, 2000 to make your option change.

If You Have Access to the Internet, Visit these Web Sites for More Information

- Medicare or Medicare+Choice: www.medicare.gov
- The Health Care Financing Administration: www.hcfa.gov
- The Social Security Administration: www.ssa.gov